

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

FILED JAN 23 1941

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

44093

Do not use this space.

1. PLACE OF DEATH

(a) County Stone Registration District No. 842
(b) Township Chase Mo. 2 Primary Registration District No. 6104 4513 Registered No. _____
(c) City _____ (If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. Chase Mo. St. ☐ (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widow
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 10-7-1861
7. AGE YEARS 79 MONTHS 2 DAYS 4 If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
9. Industry or business in which work was done, as saw mill, bank, etc. wp.
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) Lawrence Co. Mo. (STATE OR COUNTRY) Mo.

FATHER 13. NAME Stell Patterson 9

14. BIRTHPLACE (CITY OR TOWN) unknown 7 (STATE OR COUNTRY) Mo.

MOTHER 15. MAIDEN NAME unknown

16. BIRTHPLACE (CITY OR TOWN) unknown (STATE OR COUNTRY) Mo.

17. INFORMANT Mr. Cecil Spencer (ADDRESS) Chase Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Round Grove DATE 12-12-1940

19. FUNERAL DIRECTOR (NAME) Wm. L. Luman (ADDRESS) Miller Mo.

20. FILED Dec 12 1940 Mrs. Ethel Duggitt Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12-11-1940

22. I HEREBY CERTIFY That I attended deceased from 1938 to Dec 12, 1940

I last saw h. or alive on Dec-12, 1940 Death is said to have occurred on the date stated above, at 2³⁰ a. m. The principal cause of death and related causes of importance were as follows:

Hypertatic Pneumia! Date of onset 12-4-40

Other contributory causes of importance:

Infirmities of age.

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____ Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____ If so, specify _____

(Signed) A. P. Foyette M. D. (Address) Chase, Mo.

RECEIVED.

District Health Officer No. 6.

District File Number 141-101

Date Filed JAN 13 1904

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, ~~or by~~.....

....., Registered Apprentice No.
working under my personal supervision.

Signed

L. R. Leiman

Licensed Embalmer No. 3397

P. O. Address Miller M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.